Connecticut Pain Solutions
67 Masonic Avenue Suite 2400
Wallingford, CT 06492
P: 203.626.9080 | F: 203.626.9074
999 Summer Street Suite 100
Stamford, CT 06905
P: 203.724.9290 | F: 203.724.9288

****PLEASE FILL OUT ALL AREAS OF FORM****

Date: _____ Patient Email: _____

Last Name: _____ First Name: _____

SSN: _____ DOB: _____ Gender: _____ Race: _____

Ethnicity: _____ Primary Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work / Cell Phone: _____

Primary Care Physician: _____ Phone: _____

****If you have a Workers' Compensation Case or a Personal Injury Case, please skip insurance section.**

Primary Insurance Carrier: _____ ID Number: _____

Name of Insured: _____ Relationship: _____

Secondary Insurance Carrier: _____ ID Number: _____

I HEREBY AUTHORIZE AND DIRECT CNPC (CT PAIN SOLUTIONS) TO RELEASE TO GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE, ALL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH HOSPITALIZATION AND MEDICAL CARE AND PERMIT REPRESENTATIVES THEREOF TO EXAMINE AND MAKE COPIES OF ALL RECORDS RELATED TO SUCH CARE AND TREATMENT.

I ALSO HEREYBY ASSIGN, TRANSFER, AND SET OVER TO CNPC SUFFICIENT MONIES AND / OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT IN THE PRACTICE.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE. IF I AM NOT COVERED UNDER ANY INSURANCE POLICY OR PLAN, I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED DURING MY MEDICAL CARE AT CNPC.

I CERTIFY THAT THE INFORMATION GIVEN BY ME, IN APPLYING FOR PAYMENT UNDER THE TITLE XCIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO THE PHYSICIAN OR ORGANZATION PROVIDING THE SERVICES.

Signature: _____ Date: _____

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PATIENT PERSONAL INJURY INTAKE/QUESTIONNAIRE
WORKER'S COMPENSATION

If you are not being seen for a personal injury or worker's compensation claim, please disregard this form.

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Phone Number: _____

Questions about your current problem:

1. What was the date/time of your accident? Date: _____ Time: _____
2. How did it happen?

   Please check (✓) one: ☐ Accident at work ☐ Accident at home ☐ Following surgery
   ☐ Car accident ☐ Following illness ☐ Pain just began
   ☐ Other accident: _____

Employer at the time of injury: _____

Employer phone number: _____

Employer address: _____

_____

Worker's Comp OR Auto Insurance Carrier:

_____

Worker's Comp OR Auto Insurance Carrier Address:

_____

Claims Examiner/Adjuster Name: _____

Phone Number: _____ Claim Number: _____

Have you retained an attorney? (Please circle) YES / NO

Are you currently in litigation for this injury? (Please circle) YES / NO

Attorney's Name: _____

Office Phone Number: _____

If you are being seen for a worker's compensation claim, you MUST have authorization through your worker's comp insurance company prior to scheduling an appointment.

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PERMISSION FOR OPERATION OR SPECIAL PROCEDURE

1. I hereby authorize Dr. Igor G. Turok and/or such associates by him/her, to examine, treat and perform any diagnostic testing or certain procedure(s) in the office deemed necessary to properly evaluate or/and treat my condition(s). I authorize any additional unanticipated procedures as are considered necessary by my physician on the basis of findings during the course of said procedure(s). This authority extends to remedying conditions that are not known to the physician at the time the above procedure(s) is commenced.

2. I have been informed to my satisfaction and understanding by the physician of the following: 1) The general nature of the ailment; 2) The general nature of the contemplated procedures to correct or to diagnosis the ailment; 3) The recognized risks and consequences; 4) The prospects of success; 5) The reasonably anticipated consequences if the procedure is not performed; and 6) The alternative methods of treatment or diagnosis if any, and the reasonably anticipated consequences involved in each.

3. I am aware that in the practice of medicine and surgery, unexpected complications may occur. I acknowledge that no guarantees have been made to me concerning the results of the procedure(s).

4. I consent to the administration of such anesthetics as are deemed necessary by the above physician and/or his/her designated assistants in order to perform the above procedure(s). I also consent to intravenous solutions and contrast (dye) agents as maybe considered necessary or advisable by the physician responsible for this service without exceptions. Any tissues or parts surgically removed are disposed of in accordance with accustomed practice.

5. I consent to the photographing of the operation and procedures to be performed for medical, scientific or educational purposes.

I hereby warrant that I have been legally adjudged as competent. I further certify that I am fully able to understand and weigh the benefits versus the risks of the above listed procedure(s). I understand that it is my right to determine the extent of my medical care, and that I may revoke this consent at any time. I warrant that I willfully consent to the procedure and am under no duress by the above named physician, his/her assistants or staff to consent to the above listed procedure.

Date: _____

Patient Signature: _____ Patient Name Print: _____

Certification of Physician: I discussed the procedure with the patient, guardian, or representative of the patient and fully informed him/her about the potential risk, benefits, alternatives, etc.; and he/she consented to having the procedure performed and to signing this form.

Physician Signature: _____

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Controlled Substance Agreement and Informed Consent Form

The following agreement relates to my use of controlled substances including but not limited to "narcotics/opioids," to treat chronic pain. I will be provided with prescriptions only if I understand and agree to the following:

1. I understand that, depending on the drug and dose, I can become physically dependent on the medication and can develop withdrawal symptoms if the medication is stopped suddenly or the dose reduced rapidly. Although the risk is small, there is a chance of developing an addiction to controlled substances if I am placed on them to control my pain.
2. Controlled substances can cause sedation, confusion, or other changes in mental state and thinking abilities. I understand that the decision to drive while I am taking controlled substances is my own decision, and I agree not to be involved in any activity that may be dangerous to me or someone else such as driving or operating any dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself if I am in any way sedated, feel drowsy or am not thinking clearly.
3. I will not use any illegal controlled substances. I understand that if I present to the office while under the influence of illicit or intoxicated, I will not be seen and no controlled substances will be prescribed. I will not drive while intoxicated with alcohol.
4. The CNPC policy regarding the dispensing of controlled substances requires that I will be seen regularly and I agree to make and keep my appointments. I will advise my doctor of all other medicines and treatments that I am receiving.
5. If the medication requires adjustment, an appointment must be made to see the doctor. No adjustments will be made over the telephone. My careful planning is required. I understand that medication refills and adjustments are done during office appointments except under very unusual circumstances. I must stay with the prescribed dosing so that I do not run out of medication early. I understand that the CNPC policy is not to prescribe early. I agree that I will use my medication exactly as prescribed and that if I run out early, I may go without medication until the next prescription is due, possibly resulting in withdrawal symptoms.
6. I understand that the prescriptions are my responsibility once they are placed in my hand and that if anything happens to my prescription (lost, stolen, accidentally destroyed), I may not receive a replacement from my physician. CNPC expects me to file a police report if my medication is stolen. I will be prepared to bring in a copy at my next office visit.
7. My physician will prescribe whatever medication he/she is comfortable with and thinks is best; he/she is not under any obligation to prescribe any specific medication.
8. I am aware of the possible risks and benefits of other types of treatments that does not involve the use of opioids. The other treatments discussed included: Injections, therapy, and surgery (if indicated).
9. I agree to come to the CNPC with my medication on the same day that I am called and submit to a pill count, and/or urine or blood screening to detect illegal substances or confirm proper use of prescribed medicine. The call to come to the CNPC can be made either randomly, or if a concern arises. I may be required to bring my unused medication routinely to each office visit. If I do not have insurance or my insurance denies testing, I will be responsible for the cost of the test.

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10. I give permission to the CNPC staff to call any pharmacy or another health care provider at any time, without my being informed, to discuss my past or present use of controlled or illegal substances.

11. I will not use my pain medication in higher than prescribed amounts for new problems that arise (toothache, surgery, etc.) unless authorized to do so. I will inform my other doctor(s) of my use of medication for chronic pain, and I will inform the CNPC staff if another physician prescribes controlled substances for the acute problem. My doctor at CNPCC is my primary doctor with regard to my pain medications. If there is a medical emergency (e.g., broken leg, surgery requiring post-op pain medication, dental procedures, etc.), another doctor may prescribe pain medication to me, but I will advise the prescribing doctor of my care at CNPCC, authorize the doctor to disclose information to CNPC, and I will also notify my doctor at CNPCC of the medication and dosage.

12. (Females only) Because of the risks of certain medications to unborn children, I will inform all physicians, obstetrician/ gynecologist and CNPC, immediately if I become pregnant or decide to try to become pregnant. I am aware that should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware the use of opioids is not generally associated with risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

13. (Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

14. My physician can wean me off of controlled substances at any time if he/she feels that it is in my best interest. The weaning process can result in withdrawal symptoms. If I am weaned off, the CNPC staff may inform my other health care providers as the reasons for the weaning.

15. Abstinence Syndrome (Withdrawal Syndrome): Stopping opioid, anti-seizure or antidepressant medication abruptly may result in withdrawal symptoms (flu-like symptoms, GI distress, diarrhea, sweating, heart palpitations, and rarely seizures or death). I should wean from my medications rather than stopping them abruptly. If I find myself without medication, I will use the emergency line to notify my doctor.

16. I understand that in general I may be weaned off of my medication or my drug therapy may be terminated at the discretion of my physician if any of the following occur:

a) It is the opinion of my physician that controlled substances are not very effective for my pain and/or my functional activity is not improved.
b) I misuse the medication.
c) I develop rapid tolerance or loss of effect from this treatment.
d) I develop side effects that are significant and detrimental to me.
e) I obtain controlled substances from other sources other than my physician without informing him or her.
f) Pill counts or test results indicate the improper use of the prescribed medication or the use of other drugs, and/or I fail to submit to such counts/tests on the day that I am called.
g) I am arrested and/or, convicted for a controlled or illicit drug violation including drunk driving.
h) Any violation of this agreement.

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17. I further understand that my drug therapy will be terminated or detoxification in a controlled environment will be required if I give away, sell, distribute and/or transport with the intent to sell or dispense my medication.

18. I choose to use _____ Pharmacy, located at, _____, for all of my pain medication prescriptions. I will not fill partial prescriptions if my pharmacy does not stock the full quantity of medication, if I change my pharmacy for any reason, I agree to notify my pain physician.

I have read the above Agreement and understand the Agreement, have had all my questions concerning this Agreement answered to my satisfaction, and I agree to abide by the terms of this Agreement, if I am placed on controlled substances (including, but not limited to narcotic analgesics). I have received a copy of the Agreement by signing this form voluntarily; I give my consent for the treatment of my pain with narcotic/opioid pain medicines.

Date: _____

Patient Signature: _____ Patient Name Print: _____

Physician Signature: _____

Urine Drug Screening Consent

I certify that I have voluntarily provided a fresh and unadulterated urine specimen for analytical testing.

I authorize the laboratory to release the results of this testing to the requesting provider, Dr. Igor G. Turok or Tyler Mammone, APRN.

I hereby authorize my insurance benefits to be paid directly to the laboratory for services received.

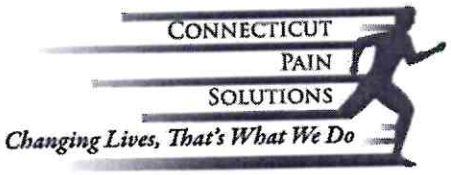
I acknowledge that the laboratory may be an out of network facility and services not covered will be by responsibility including deductibles, co-payments and co-insurance.

I acknowledge that in some circumstances my insurance provider will send the payment directly to me and I agree to endorse the insurance check and forward it to the laboratory within 30 days of receipt as payment toward the claim.

Date: _____

Patient Signature: _____ Patient Name Print: _____

Physician Signature: _____



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Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any nears or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient where born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated, with or serving as a backup for the healthcare provider, including those working at the healthcare providers clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty (30) days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such parties pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including council fees, witness fees, or other expenses incurred by a party for such parties own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

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The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover noneconomic losses, and the right to have a judgement for future damages conformed to periodic payments, shall apply to disputes within this ARBITRATION AGREEMENT. The parties further agree that the COMMERCIAL ARBITRATION RULES of the AMERICAN ARBITRATION ASSOCIATION shall govern any arbitration conducted pursuant to this ARBITRATION AGREEMENT.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within thirty (30) days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____ Effective as the date of first professional services.

If any provisions of this ARBITRATION AGREEMENT is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be effected by the invalidity of any other provision. I understand that I have the right to receive a copy of this ARBITRATION AGREEMENT. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUES OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRAIL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name: _____ Date: _____

Patient Signature: X _____

Physician Signature: X _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have received a copy of the Notice of Privacy Practices of CNPC (CT Pain Solutions).

Signature: _____ Date: _____

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM PROVIDERS

I hereby authorize Igor G. Turok, M.D. or any employee of Comprehensive Neurology and Pain Center of Connecticut, L.L.C. to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me at any time.

I also authorize Comprehensive Neurology and Pain Center of Connecticut, L.L.C. to release any and all medical records concerning my care to any physician, hospital, or other health care professional providing care to me at any time. Additionally, I authorize Comprehensive Neurology and Pain Center of Connecticut, L.L.C. to release any and all medical records concerning my care to Medicare, Medicaid, Insurance Company, third party administrators, or Managed Care Company.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

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AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

Patient Name: _____ DOB: _____

I give permission to Comprehensive Neurology and Pain Center of CT, LLC (CT Pain Solutions) to discuss my personal health information with the following authorized person(s):

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Patient Signature: _____

EMERGENCY CONTACT

I authorize Comprehensive Neurology and Pain Center of CT, LLC (CT Pain Solutions) to contact the following individual in the event of an emergency situation.

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

Patient Signature: _____

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Late and Missed Appointments

At Comprehensive Neurology & Pain Center of CT we put our faith in you to keep your appointment. When we set up an appointment, specific amount of time is reserved especially for you based on your treatment plan.

If for any reason you must cancel or change your appointment, it is important that you give our office **at least 24 hours' notice** to offer that spot to someone else.

- **1st missed appointment:** If an appointment is missed or canceled within the 24 hour window, a call or letter will be sent to your home reminding you of our policy and the effects of your missed appointment. We also reserve the right to charge you missed appointment rates stated below.

- **2nd missed appointment:** After your second missed appointment, a letter will be sent to your home notifying you of a change in status of your account. In order for you to schedule a future appointment with our doctors, a deposit must be made. The deposit is 50% of the cost of that appointment, or $100.00 whichever is greater. Upon arrival, this fee is credited toward the cost of the patient's treatment. If the patient does not show up to the appointment the deposit is non-refundable. If you choose to not pay the deposit you have the option of being placed on a short notice list and will be notified of last minute scheduling opportunities.

- **After 2 missed appointments,** the patient will be placed on a short notice list and will be notified when there is a cancellation or opening in the schedule. No appointments can be scheduled ahead of time until the patient's account is placed back in good standing. The decision to place the patient's account back in good standing lies at the sole discretion of the practice manager.

We understand that true emergencies happen. If this is the case, please provide us with a doctor's note or other adequate proof and the missed appointment will be removed from your accounts record.

Late arrival: When we reserve time for you, we require all of that time to provide you with the best quality care possible. When you are late it decreases our ability to accomplish this. If you arrive more than 15 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment.

Missed Appointment Rates: Consultation - $50 / Follow up - $50.00 / Procedures - $75.00

I have read the policy above. I understand and agree to abide by the listed terms.

Date: _____

Patient Signature: _____ Patient Name Print: _____

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MEDICATION LIST

PLEASE LIST ALL TABLETS, PATCHES, DROPS, OINTMENTS, AND INJECTIONS. INCLUDE PRESCRIPTION, OVER THE COUNTER, HERBAL, VITAMIN AND DIET SUPPLEMENTS. LIST ANY MEDICATION YOU TAKE OCCASIONALLY. PLEASE NOTIFY OUR STAFF OF ANY CHANGES TO YOUR MEDICATION LIST

MEDICATION	DOSE	FREQUENCY	PRESCRIBER

Patient Name: _____ Date: _____ DOB: _____

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Patient Medical History

Reason for Visit: _____

_____

Weight: _____ pounds **Height:** _____ inches

Allergies to medications: (Y / N)
If yes, list medications: _____

Do you use Tobacco?(Y / N) If yes, how often? _____
Do you drink alcohol? (Y / N) If yes, how often? _____
Illicit drug use? (Y / N) If yes, how often? _____

Have you had any recent imaging (MRI, CT scan, etc.) done? _____

Past Medical History
Please circle all that apply: High blood pressure, stroke, diabetes, arthritis, seizures, heart attack, asthma, cancer (type: _____), high cholesterol, depression, anxiety
Other: _____

_____

Surgeries:

Date	Description

Hospitalization (not including surgeries):

Date	Description

Family Medical History: _____ No significant family history is known
Mother: _____
Father: _____
Siblings: _____

Patient Signature: _____ **Date:** _____

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Please complete questionnaire based on current condition and symptoms. This information is for our records and will remain confidential. Your treatment will not be based upon this questionnaire alone.

Name: _____ Date of Birth: _____

Date of Assessment: _____

Please answer the questions below using the following pain scale:

0 – Never, 1 – Seldom, 2 – Sometimes, 3 – Often, 4 – Very Often

1. How often do you have mood swings?	0	1	2	3	4
2. How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
4. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
5. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
6. How often have you attended and AA or NA meeting?	0	1	2	3	4
7. How often have you taken medication other than the way that it was prescribed?	0	1	2	3	4
8. How often have you been treated for and alcohol or drug problem?	0	1	2	3	4
9. How often have your medications been lost or stolen?	0	1	2	3	4
10. How often have others expressed concern of your use of medication?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4

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0 – Never, 1 – Seldom, 2 – Sometimes, 3 – Often, 4 – Very Often

12. How often have you been asked to give a urine drug screen for substance abuse?	0	1	2	3	4
13. How often have you used illegal drugs (i.e. marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
14. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

Please include any additional information you wish about the above answers. Thank you.